Explanation of Profiler Fields
January 10, 2007

Enrollee – A person who is on Medicaid and enrolled in Patient 1st
Recipient – An enrollee who has received a service
Panel – Total number of enrollees
**** Unless otherwise stated, calculation s include both referrals and non-referrals.

Unique – Recipient is only counted once
PMP – Information specific to your panel
Profiler only reflects patients in your panel unless specified

Field	***Description***
Average Age – PMP and Peer Group	The average age is based on all enrollees on the PMP's panel within the time period. The average age is calculated using the sum of all the ages divided by the unique number of enrollees.
Panel Size	Total number of unique enrollees assigned at any time to the PMP for the report period. If the PMP has multiple provider numbers, then all information is linked to the PMP's unique number.
Total Member Months	Total number of months enrollees were on the PMP's panel. This is calculated adding all the days that an enrollee is eligible within the PMP panel and dividing by 30.
Morbidity Index	Illness burden of Patient 1st recipients on a provider's panel compared with the illness burden of recipients assigned to the provider peer group. A value of less than 1.00 demonstrates that a provider's practice has a lesser illness burden whereas greater than 1.00 demonstrates a higher illness burden. Utilizes Adjusted Clinical Groupings (ACG) weights designed by Johns Hopkins University.
Cost Per Recipient	This is the average cost per recipient for the PMP. This is calculated by dividing the total allowed amounts of Inpatient, Pharmacy, Medical, Outpatient, and Dental claims by the total distinct number of recipients assigned to the PMP. These figures are ***not*** morbidity adjusted.
Peer Group Size	Total number of providers in the PMP's peer group. Peer group is based on specialty.
Claim Rank	Ranking of the number of claims filed for recipients on the PMP's panel within the PMP's peer group.
Recipient Rank	Ranking of the number of recipients on the PMP's panel within the PMP's peer group.
Enrollee Age Breakdown	This bar chart displays the age percentages for each age group per the PMP and the Peer Group.
Cost Per Recipient	Explained above.
Number of Recipients	The number of recipients on the PMP's panel that actually received a service.
Total Costs	Total allowed amount of all Inpatient, Outpatient, Pharmacy, Dental, and Medical claims for the PMP. These figures are ***not*** adjusted.

Field	***Description***
Office Visits Per Recipient	Total number of office visits divided by the unique number of recipients receiving this service. These figures are ***not*** adjusted. (Office visits include medical claims with procedure codes of 99201-99215, 99241-99245, 99271-99275)
Office Visits Per Recipient – Peer Group	As above. NOTE: This calculation excludes the claim count and recipient count of the PMP.
Claims Per Recipient	Total number of claims divided by unique number of recipients.
Panel General Service Characteristics	*These calculations are reflective of the recipients on the PMP's panel receiving services, they **are** morbidity adjusted and includes both referrals and non-referrals.*
Ambulatory	Services provided in the hospital outpatient setting, ASC setting, DME, home health, lab, x-ray and physician office.
Inpatient	Services provided in an inpatient setting billed as per diems.
Pediatric Dental	Information pulled from dental claims.
Pharmacy	Prescription Drugs. This calculation includes all claims whether PMP wrote the prescription or someone else wrote the prescription for one of the PMP panel members.
Totals	The recipient totals for ambulatory, medical, dental and inpatient are unique within each subset. The total will not be the sum of each subset for recipients.
Recipient Count	Total unique number of recipients receiving this service.
Total Claims	Total number of claims meeting the service criteria
Actual Amount	Total allowed amount.
PMPM	This is calculated based on the allowed amount divided by the total enrollee months for the PMP. ENROLLEE VS RECIPIENT NOTE: Average Length of Stay and Number of Admissions reflect claim count rather than dollar amount.

Field	***Description***
Expected PMPM	This calculation is the total allowed amount for all services divided by the member months for patients in the peer group who have the same morbidity level as enrollees of the PMP panel. The result is the expected cost if the PMP's enrollees were treated by members of the peer group.
Panel Specific Service Characteristics	*This information is specific to certain services. These calculations are reflective of the recipients on the PMP's panel receiving services, they are morbidity adjusted and includes both referrals and non-referrals.*
Pediatric Dental	Dental claims.
Pediatric EPSDT Periodic Screenings	Medical claims. (Procedure codes 99381-99385 and 99391-99395; Modifier EP)
Pediatric Immunizations	Medical and Outpatient claims filed with immunization procedure codes. (Age group 0 – 15, procedure codes 90645; 90647; 90648; 90655-90658; 90669; 90700; 90702; 90707;90713-90716; 90718; 90721; 90723; 90732-90734; 90744; 90748)
Admissions Per 1000	This field is calculated based on the inpatient claim count divided by member months * 1000 * 12. The calculation accounts for fee-for-service and encounter claims.
Average Length of Stay	This field is based on the inpatient Total Covered Days divided by the claim count.
Certified ER Visits	Outpatient emergency room claims that have been certified as an emergency by the attending physician. (Procedure codes 99281-99285 and emergency indicator = Y)
Lab Services	Medical and Outpatient claims for lab procedures other than the professional component. (Procedure codes 80000-80499; 80503-89999; Q0111-Q0115; Q0123-Q0126; Q0141-Q0148, P2028-P2033; P2038; P3000-P3001; P7001; Q0091-Q0092)
Non Certified ER Visits	Outpatient emergency room claims that WERE NOT certified as an emergency by the attending physician. (Procedure codes 99281-99285 and emergency indicator = N)
Primary Care Visits	Medical claims filed by physicians with a primary care specialty. (Procedure codes 99201-99215; 99241-99245; 99271-99275)
Radiology	Medical and Outpatient claims for radiology procedures other than professional component. (Procedure codes 70010-79999; A4641; A4644 – A4645; A9500-A9505; A9600-A9600; G0125; G0130; G0219; G0234; R0070-R0075)

Field	***Description***
Specialty Care Visits	Medical claims filed by physicians with a specialty OTHER than primary care. (Procedure codes 99201-99215; 99241-99245; 99271-99275)
Percent of Patients Seen	This is the percent of recipients seen by the PMP compared to number of enrollees on the PMP panel. The calculation takes the distinct number of recipients of Office Visits that were seen by the PMP and divides the number of enrollees on the PMP panel. The same calculation is used for the Peer Group. This data is **not** morbidity adjusted. (Procedure codes 99201-99215, 99241-99245 and 99271-99275)
Specialty Visit Referral Rate	This is the percent of recipients that have specialty visit referrals compared to the number of enrollees on the PMP panel. The calculation takes the distinct number of recipients of receiving a specialty visit and divides that number based on total PMP enrollees. The same calculation is used for the Peer Group. This data is **not** morbidity adjusted. (Procedure codes 99201-99215; 99241-99245; 99271-99275; and performing/billing provider specialty not equal to primary care)
Pharmacy Measures	*Only includes the amounts and counts for prescriptions that were written by the PMP.*
Prescription Characteristics **Panel PMP RX, Panel PMP $,** **Expected Peer Group RX, Expected Peer Group $** **(Generic, Multi-source, Single-source)**	These charts reflect all prescription drug claims broken into generic brand, multi source and single source written for patients on the PMP's panel. Panel PMP indicates that the PMP wrote the prescription. The same logic applies to the Peer Group, but the Peer Group amounts are adjusted.
Prescription Dollars **Panel PMP PMPM, Panel PMP Allowed, Peer Group PMP PMPM Expected** **(Preferred Generic, Preferred Brand, Non-Preferred and Other)**	These charts reflect the allowed amount for the Preferred Generic, Preferred Brand, Non-preferred and Other. Other is defined as those drugs that have not been reviewed for the Preferred Drug List. Panel PMP indicates that the PMP wrote the prescription. The same logic applies to the Peer Group. These dollar amounts are based on the actual allowed amount divided by the member months.
Your Top Drugs by Total Allowed and Number of Prescriptions	*Ranking based on the allowed amount and number of paid prescriptions for the drug.*

Field	***Description***
Drug Name	The name associated with the Drug Code (NDC) on the Pharmacy Claim.
# RXs	The total number of prescriptions written per Drug Code (NDC).
Total Allowed	The total allowed amount for each drug.
# Undup Recipients	The total number of unique recipients that were prescribed each NDC.
PMP % of Total Allowed	The percentage of total dollars allowed for prescriptions written by the PMP for that drug.
Peer Group % of Total Allowed	The percentage of total dollars allowed for prescriptions written by the Peer Group PMPs for that drug. This calculation is based on the entire peer group.
Average Cost Per RX	The average cost per prescription for the identified drug.
Performance Measures	*These measures (as indicated with an asterisk below) are the measures by which performance payments will be based. These quarterly measures will help you as the PMP to gauge your performance. The actual payment will be based on an aggregate run of data for a one-year period of time.*
Performance Measure: Generic Dispensing Rate*	The PMP portion is calculated based on the claim count of generic drugs written compared to the total of all drug claims. The expected calculation is the total allowed amount for all services divided by the member months for patients in the peer group who have the same morbidity level as enrollees of the PMP panel. The result is the expected cost if the PMP's enrollees were treated by members of the peer group.
Performance Measure: Office Visits Per Unique Enrollee (Annualized)*	The PMP portion is calculated based on the number of non-referral office visits per PMP enrollee member months. The calculation takes the number of office visits of the PMP and divides this number by the PMP member months. The expected calculation is the total allowed amount for all services divided by the member months for patients in the peer group who have the same morbidity level as enrollees of the PMP panel. The result is the expected cost if the PMP's enrollees were treated by members of the peer group. The results are multiplied by 12 to annualize. (This calculation is based only on the PMP non-referrals of office visits. Office Visits are based on claims with procedure codes 99201-99215, 99241-99245 and 99271-99275)

Field	*Description*
Performance Measure: **Average Number of Non-Certified Emergency Room Visits (Annualized)***	The PMP portion is calculated based on the number of non-certified emergency room visits per PMP enrollee member months. The calculation takes the number of non-certified emergency room visits received by the PMP's recipients and divides this number by the PMP member months. The expected calculation is the total allowed amount for all services divided by the member months for patients in the peer group who have the same morbidity level as enrollees of the PMP panel. The result is the expected cost if the PMP's enrollees were treated by members of the peer group. The results are multiplied by 12 to annualize. (This calculation is based only on the PMP Non-Certified Emergency Room visits with a procedure code 99281-99285 and emergency indicator not equal Y)
Info Solutions Data	This is the number of times a provider has utilized Info Solutions for the period specified. NOTE: That this time period differs from the Provider Profiler time period.